OIPE JC163 SEP 10 2004 PATENT & TRADEMARK OFFICE

100

Administrative Services

ENROLLMENT FORM

125
Allen B. Smith 105 115
Employee Name 130 120
123 4567 89
Social Security Number 110
Employee Home Street Address
City State Zip
Date of Birth Daytime Phone Number

Employee E-Mail Address
Employer Name
Plan Year
Number of Pay Periods in Plan Year
Division (as applicable)

Health Care Spending Account - allows you to use pre-tax dollars to pay for expenses, which are not 100% covered or are ineligible for payment through any group health care plan(s) under which you or your spouse are covered. Please check your selection:

☐ Yes,I elect to participate: ____ (Plan Year Contribution) ÷ ____ (# of Pay Periods in Plan Year) = ____ (Pay Period Pre-Tax Contribution)
☐ No,I elect not to participate

Dependent Care Spending Account - allows you to use pre-tax dollars to pay for eligible dependent care (i.e.daycare) expenses, which enable you, or your spouse (if applicable) to work or attend school on a full-time basis. Please check your selection:

☐ Yes,I elect to participate: ____ (Plan Year Contribution) ÷ ____ (# of Pay Periods in Plan Year) = ____ (Pay Period Pre-Tax Contribution)
☐ No,I elect not to participate

Premium Payment Plan - This may be an optional plan offered by your employer. Please check your Plan Highlights or with your Human Resources department to confirm if your company is offering this benefit and if you are required to make an election. The Premium Payment Plan allows you to pay for your portion premiums and that of your dependent(s) (as defined in Section 152) of employer-provided benefits on a pre-tax basis. Please check your selection:

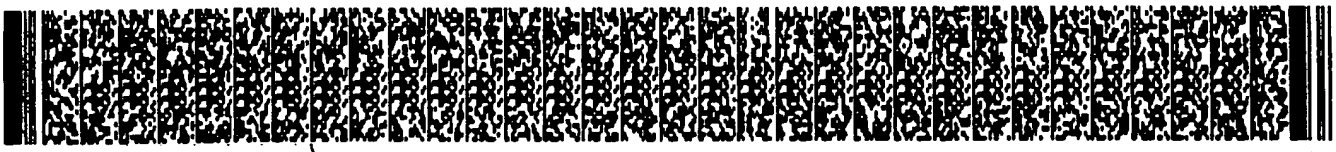
☐ Yes,I elect to participate ☐ No,I elect not to participate

I authorize the above elections and the subsequent adjustments to my base annual salary. I acknowledge there is a grace period in which to submit reimbursement requests for expenses incurred during the plan year, and upon expiration of the grace period, any unused funds will be forfeited. I hereby acknowledge my monthly pre-tax premium contributions are subject to change at my company's discretion. I understand I will be notified in advance of any changes. I understand my elections are binding for the entire plan year and cannot be altered, other than by my employer, or unless I experience a qualifying status change. I understand I may experience future reduction in life, disability, and Social Security benefits by participating in the Flexible Spending Plan. I understand, at the option of my employer, my election in relation to the Premium Payment Plan may automatically continue in subsequent plan years. Furthermore, I consent to use of my treatment, payment and health care operation information as defined under HIPAA, for the purpose of administering my Flexible Spending Account(s).

X ____ Participant Signature for Flexible Spending Account(s)
X ____ Date

Must Be Completed By Employer:

Date of Hire | Effective Date | Payroll Cycle | Payroll Number | Employer Initials | Date



135

FIG. 1

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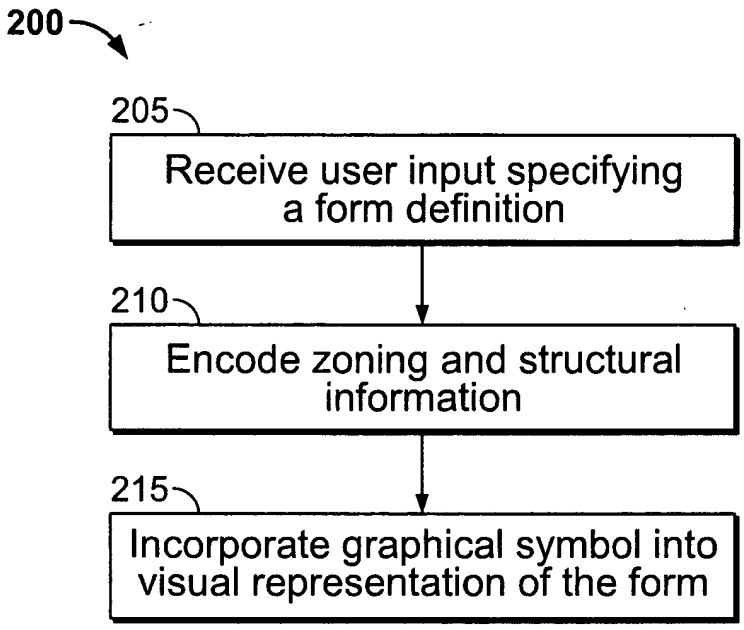

FIG. 2

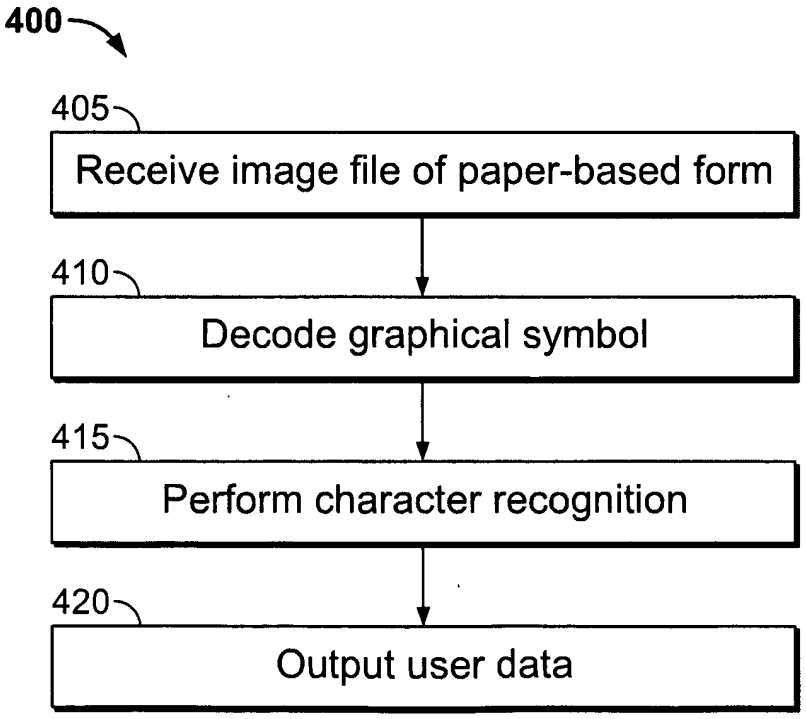

FIG. 4

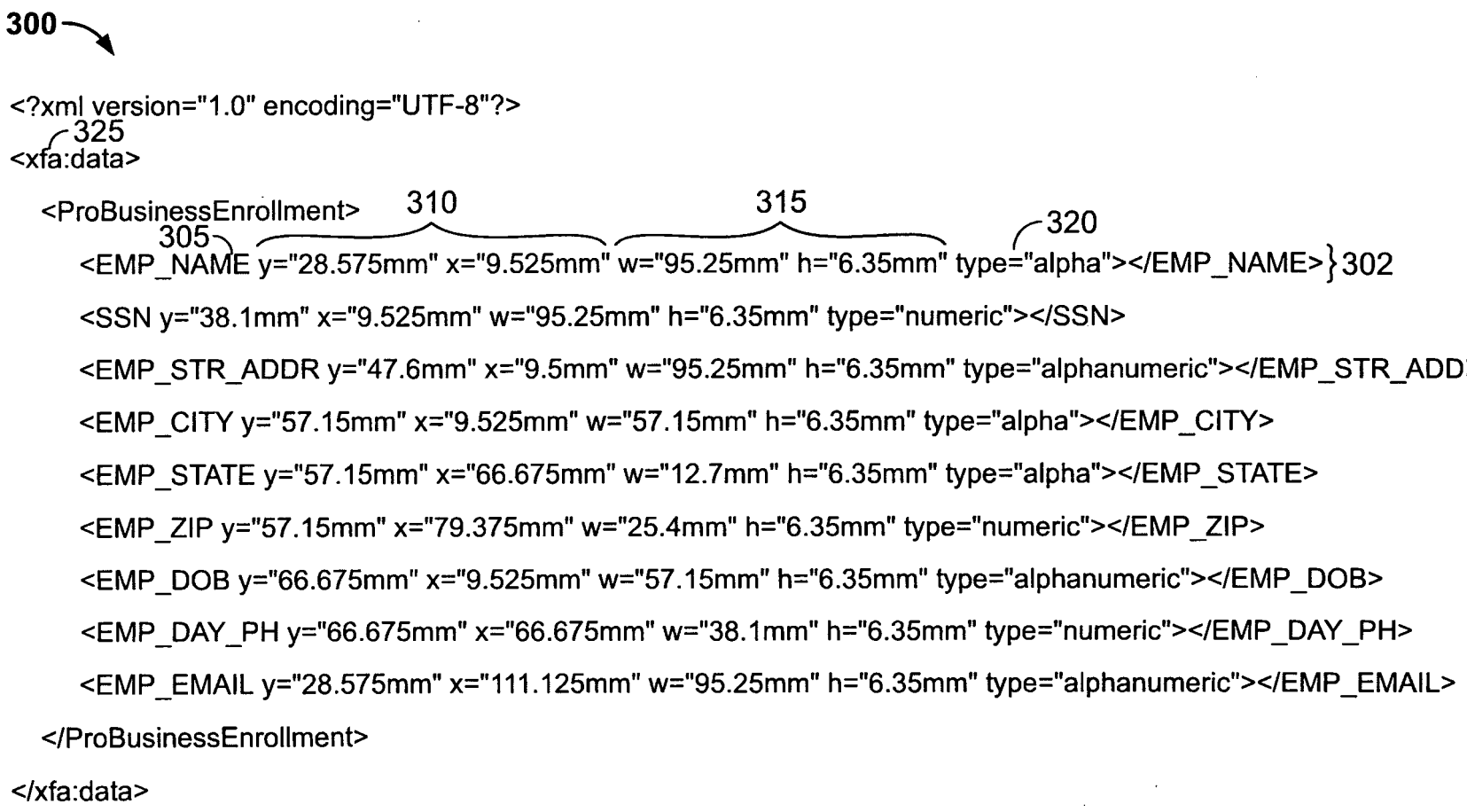
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FIG. 3